DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 4 — 0 4

2. STATE: Michigan

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447 Subparts B & C

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $ -0-
b. FFY 2005 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A pages 5, 5.1, 8, 13 thru 16 and 16.1 and Appendix A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A pages 5, 8 and 13 thru 16 and Appendix A

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Paul Reinhart, Director
Medical Services Administration

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Paul Reinhart

14. TITLE:
Director

15. DATE SUBMITTED:

16. RETURN TO:
Medical Services Administration
Program Policy-Federal Liaison Unit
400 South Pine - 7th Floor
Lansing, Michigan 48933

ATTN: Nancy Bishop

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
APR 29 2004

18. DATE APPROVED:
JAN 14 2005

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
APR - 1 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

22. TITLE:
DCD

23. REMARKS:

RECEIVED
APR 29 2004
DMCH - MI/MN/WI

FORM HCFA-179 (07-92)

Instructions on Back

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
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METHODS OF PAYMENT OF REASONABLE COSTS -
INPATIENT HOSPITAL SERVICES

- Limit episodes to those with a valid patient status (incomplete episodes are excluded as are additional pages of multiple page claims where there is no initial claim containing a valid patient status);

- Eliminate episodes with a zero dollar Medicaid liability;

- Determine the 3rd and 97th percentile length of stays by DRG, the average length of stay, and the maximum length of stay.

  - Set the low day outlier threshold at the greater of one day or the 3rd percentile length of stay.

  - Set the high day outlier threshold at the lesser of the average length of stay plus 30 days or the 97th percentile length of stay.

  - If the DRG has less that an adequate number of episodes (currently 32), the low day threshold will be set at the lesser of the average length of stay plus 30 days, the maximum length of stay, or the Medicare DRG 90th percentile length of stay (from the corresponding Grouper as published in the Federal Register). If the Medicare DRG also has an inadequate number of claims, then the threshold is set based upon the expert advice of the MSA's medical staff.

- Eliminate low day outliers (Low day outliers are those episodes whose length of stay are less than the published low day threshold for each DRG. Since low day outliers are paid under a percent of charge method using the hospital's cost to charge ratio times charges, and do not receive a DRG payment, they are excluded from the weight calculations);

- Calculate the arithmetic mean length of stay for each DRG with each episode's length of stay limited to the high day threshold set above. This serves as the final published average length of stay.

- Limit episodes ending in a transfer to another acute setting to those whose length of stay was at least equal to the published average length of stay for the DRG (for DRGs 385 and 385.1 all transfers are included);

- Bring all charges for admissions in the first and second years of the base period up to third year charges through application of inflation and weighting factors;

- Recognize area cost differences by dividing the charges for each hospital by an area cost adjustor factor. Hospitals are grouped by U.S. Census Metropolitan Statistical Areas (MSAs) for wage data as published in the Federal Register. Hospital geographic reclassifications made under Section 508 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 will not be used to calculate the update to hospital prices and the DRG table effective April 1, 2004. Otherwise, the most recent data is used. Each area cost adjustor is calculated as follows:

  - Cost Adjustor = 0.9 x Wage Adjustor + 0.1

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- This formula is the algebraic deviation of:
  - 0.75 x Wage Adjustor + 0.25 x (0.6 x Wage Adjustor + 0.4)

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- The average cost for episodes within each DRG is calculated by dividing the sum of the costs for the episodes by the number of episodes within the DRG.

- The relative weight for each DRG is calculated by dividing the average cost for episodes within each DRG by the average cost per episode for all episodes. A table showing the relative weights, average lengths of stay, and outlier thresholds for each DRG is included in Appendix A.

- Bring all charges for discharges between September 1, 1997 and August 31, 1999 to the period of September 1, 1999 through August 31, 2000 through application of inflation and weighting factors.

Data for current wage adjustors are taken from hospital cost reporting periods ending between September 1, 1998 and August 31, 2001. Each hospital's wage costs are adjusted for different fiscal year end dates by multiplying the hospital's wage costs by inflation and weighting factors. All wages are brought to a common point in time. Filed wage data is used for hospitals where audited data is not available. The following adjustment factors derived from the 2nd Quarter 2003 Data Resources, Inc. PPS-Type Hospital Market Basket Index, employee cost component, are used:

FTE	Wage Inflation Factors	Wage Weighting Factors
9/30/98	1.1195	0.16
12/31/98	1.1109	0.16
3/31/99	1.1023	0.16
6/30/99	1.0939	0.16
9/30/99	1.0861	0.24
12/31/99	1.0771	0.24
3/31/00	1.0673	0.24
6/30/00	1.0567	0.24
9/30/00	1.0455	0.60
12/31/00	1.0345	0.60
3/31/01	1.0229	0.60
6/30/01	1.0116	0.60
8/31/01	1.0000	0.60

For hospitals with cost reporting periods ending other than at the end of a quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.

B. DRG Price:

The episode file used for DRG price calculations is the same as the file used to set the relative weights with the following exceptions:

- The episode file is limited to those hospitals enrolled as of a specified date.

- The case mix is calculated using the sum of all relative weights assigned to each hospital's claims during the base period, divided by the total number of episodes for the hospital during the same period.

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Readmissions for an unrelated condition, whether to the same or a different hospital, are considered separate episodes for payment purposes.

7. Percent of Charge Reimbursement

The payment amount for claims that fall into DRGs 103, 468, 480, 481, 495, 512 or 513 is total hospital charges times the hospital's inpatient operating cost to charge ratio excluding IME.

The ratio is the hospital's Title XIX inpatient operating cost to charge ratio as obtained from weighted filed cost reports for fiscal years ending between September 1, 1997 and August 31, 2000.

8. Hospitals Outside of Michigan

Medical/surgical hospitals not located in Michigan are reimbursed under the DRG system. The DRG price is the statewide operating cost limit (truncated mean of base prices located in Michigan).

Hospitals that have charges that exceed $250,000 during a single fiscal year (using the State of Michigan fiscal year - October 1st through September 30th) may be reimbursed the hospital's inpatient operating cost to charge ratio for those Michigan Medicaid DRGs reimbursed by percentage of charge. The hospitals' chief financial officer must submit and the MSA must accept documentation stating the hospital's Medicaid cost to charge ratio in the state that the hospital is located. Once accepted, the hospital's actual cost to charge ratio is applied prospectively to those DRGs and claims subject to percentage of charge reimbursement using the Michigan DRG payment system.

9. New Hospitals

A new medical/surgical hospital is one for which no Michigan Medicaid program cost or paid claims data exists during the period used to establish hospital specific base rates or one which was not enrolled in the Medicaid program when hospital specific base prices/rates were last established. Hospitals that experience a change of ownership or that are created as the result of a merger are not considered new hospitals.

The DRG base price for new general hospitals is the statewide operating limit until new DRG base prices are calculated for all hospitals using data from time periods during which the new hospital provided services to Medicaid beneficiaries.

D. Hospitals and Units Exempt from DRG Reimbursement

1. Calculating Per Diem Rates

The per diem prices calculated for the Michigan Medicaid system utilize Medicaid and Children's Special Health Care Services inpatient claims for admissions from September 1, 1998 through August 31, 2002 paid by June 30, 2003. Hospital

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specific cost report data is drawn from cost report years ending between September 1, 1999 and August 31, 2002.

The claim file is limited to those hospitals enrolled as of the specified date.

The invoice file is adjusted to:

- Eliminate episodes with any Medicare charges. (For dual Medicare/Medicaid eligible beneficiaries, only claims paid a full Medicaid DRG are included);
- Eliminate episodes without any charges or days.
- Limit episodes to those from Michigan hospitals (provided that hospital cost report data are available).
- Limit episodes to those with a valid patient status (incomplete episodes were excluded as are additional pages of a multiple page bills where there is no initial claim containing a valid patient status).
- Eliminate episodes with a zero dollar Medicaid liability.

Total charges and days paid are summed by hospital.

The cost for each hospital is calculated by multiplying the charges for the hospital by the cost to charge ratio for the hospital.

- Each hospital's operating cost to total charge ratio is obtained from weighted filed cost reports for fiscal years ending between September 1, 1999 and August 31, 2002. If the cost to charge ratio is greater than 1.00, then 1.00 is used. For distinct part rehabilitation units, this ratio is unique to the unit.
- If two or more hospitals merged and are now operating as a single hospital, a cost to charge ratio is computed using the combined cost report data from all hospitals involved in the merger. Cost and charge data will be inflated to a common point in time.

The cost per day by hospital is calculated by dividing the sum of the costs by the number of days for the hospital.

To determine a hospital specific Per Diem base rate:

- Multiply the cost per day by the applicable inflation factor. Each hospital's costs are inflated to a common point in time. Inflation factors were obtained from the 2nd Quarter 2003 Data Resources, Inc. PPS-Type Hospital Market Basket Index.

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FTE	Cost Inflation Factors	Weighting Factors
9/30/99	1.1093	0.16
12/31/99	1.1017	0.16
3/31/00	1.0924	0.16
6/30/00	1.0822	0.16
9/30/00	1.0714	0.24
12/31/00	1.0609	0.24
3/31/01	1.0494	0.24
6/30/01	1.0389	0.24
9/30/01	1.0294	0.60
12/31/01	1.0210	0.60
3/31/02	1.0142	0.60
6/30/02	1.0072	0.60
8/31/02	1.0000	0.60

The inflation update for the quarter in which the hospital's fiscal year ends is used.

- Recognize area cost differences by dividing the cost per day for each hospital by an area cost adjustor factor. Hospitals are grouped by U.S. Census Metropolitan Statistical Area (MSAs) for wage data as published in the Federal Register. Hospital geographic reclassifications made under Section 508 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 will not be used to calculate the update to hospital prices and the DRG table effective April 1, 2004. Otherwise, the most recent data is used. Each area cost adjustor is calculated as follows:

  - Cost Adjustor = 0.9 x Wage Adjustor + 0.1
  - This formula is the algebraic derivation of:

    0.75 x Wage Adjustor + 0.25 x (0.6 x Wage Adjustor + 0.4)

    The formula is based on the assumption that approximately 75% of a hospital's operating costs are labor costs and that 60% of the remaining 25% of a hospital's operating costs vary with its labor costs.

  - Each area wage factor is area wage per full-time equivalent (F.T.E.) divided by the statewide average hospital wage per F.T.E. Contract labor costs are included in determining a hospital's wage costs.

  - Each hospital's wage costs are adjusted for different fiscal year end dates by multiplying the hospital's wage costs by inflation and weighting factors. All wages are brought to a common point in time. Filed wage data is used where audited data is not available. The following adjustment factors, derived from the 2nd Quarter 2003 Data Resources, Inc. PPS-Type Hospital Market Basket Index, employee cost component, are used:

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3/31/99	1.1023	0.16
6/30/99	1.0939	0.16
9/30/99	1.0861	0.24
12/31/99	1.0771	0.24
3/31/00	1.0673	0.24
6/30/00	1.0567	0.24
9/30/00	1.0455	0.60
12/31/00	1.0345	0.60
3/31/01	1.0229	0.60
6/30/01	1.0116	0.60
9/30/01	1.0000	0.60

For hospitals with cost reporting periods ending other than the end of a quarter, the inflation update for the quarter in which the hospital's fiscal year ends is used.

- ➢ The wage data for distinct part rehabilitation units is the same as for the inpatient medical/surgical area of the hospital. The cost reports do not differentiate salaries/hours by unit type.

- ➢ If two or more hospitals merge and are now operating as a single hospital, salary and wages are computed using the combined cost report data from all hospitals involved in the merger. Salary data will be inflated to a common point in time.

- Remove indirect medical education (IME) costs by dividing by an adjustor for indirect education. Each hospital's IME adjustor is calculated as follows:

  - ➢ $IME\ Adjustor = 1 + 0.715 \times [(1 + Interns\ \&\ Residents/Beds)^{0.5795} - 1]$

  - ➢ Distinct part rehabilitation units report this data separately. The IME adjustor is unique to the unit.

  - ➢ If two or more hospitals merge and are now operating as a single hospital, indirect medical education data is computed using the combined cost report data from all hospitals involved in the merger.

To determine the per diem rate:

- Calculate the statewide operating cost limit (by provider type). This is a weighted mean of all hospitals' specific base prices weighted by base period days (truncated mean), multiplied by the appropriate percentage.

  - ➢ For freestanding rehabilitation hospitals the percentage is 150%.

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➢ The 50th percentile is determined by calculating a standardized rate for each unit. The standardized rate for all enrolled Michigan units are sorted

DRG Grouper 21.0 R2, effective for admissions on and after April 1, 2004.

List of Diagnosis Related Groups (DRGs), Relative Weight Factors, Arithmetic Length of Stays, and Length of Stay Outlier Cutoff Points used in the Prospective Payment System for the Michigan Medicaid Program.

DRG	MDC	Med/ Surg	DRG Description	Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
1	1	SURG	Craniotomy Age >17 w cc	5.2533	12.36	1	43
2	1	SURG	Craniotomy Age >17 w/o cc	2.9805	5.86	1	18
3	1	SURG	Craniotomy Age 0-17	2.5207	7.16	1	38
4	1	SURG	No Longer Valid				
5	1	SURG	No Longer Valid				
6	1	SURG	Carpal Tunnel Release	0.7070	1.25	1	7
7	1	SURG	Periph & Cranial Nerve & Other Nerv Syst Proc w cc	2.7468	9.28	1	34
8	1	SURG	Periph & Cranial Nerve & Other Nerv Syst Proc w/o cc	1.6858	2.99	1	12
9	1	MED	Spinal Disorders & Injuries	1.3771	4.57	1	13
10	1	MED	Nervous System Neoplasms w cc	1.5859	6.23	1	24
11	1	MED	Nervous System Neoplasms w/o cc	1.0146	3.90	1	12
12	1	MED	Degenerative Nervous System Disorders	1.3549	6.38	1	23
13	1	MED	Multiple Sclerosis & Cerebellar Ataxia	1.1601	5.94	1	19
14	1	MED	Intracranial Hemorrhage & Stroke w Infarct	1.9041	6.83	1	24
15	1	MED	Nonspecific Cva & Precerebral Occlusion w/o Infarct	1.2577	4.68	1	16
16	1	MED	Nonspecific Cerebrovascular Disorders w cc	1.9564	7.76	1	26
17	1	MED	Nonspecific Cerebrovascular Disorders w/o cc	0.9967	3.47	1	18
18	1	MED	Cranial & Peripheral Nerve Disorders w cc	1.2244	5.76	1	24
19	1	MED	Cranial & Peripheral Nerve Disorders w/o cc	0.8261	3.60	1	12
20	1	MED	Nervous System Infection Except Viral Meningitis	2.4489	9.04	1	30
21	1	MED	Viral Meningitis	0.6504	3.13	1	8
22	1	MED	Hypertensive Encephalopathy	1.5114	5.16	1	18
23	1	MED	Nontraumatic Stupor & Coma	0.8692	3.30	1	15
24	1	MED	Seizure & Headache Age >17 w cc	1.0616	4.16	1	15
25	1	MED	Seizure & Headache Age >17 w/o cc	0.6858	2.91	1	10
26	1	MED	Seizure & Headache Age 0-17	0.5797	2.48	1	8
27	1	MED	Traumatic Stupor & Coma, Coma >1 Hr	1.5874	4.30	1	20
28	1	MED	Traumatic Stupor & Coma, Coma <1 Hr Age >17 w cc	1.3294	4.55	1	23
29	1	MED	Traumatic Stupor & Coma, Coma <1 Hr Age >17 w/o cc	0.7411	2.76	1	8
30	1	MED	Traumatic Stupor & Coma, Coma <1 Hr Age 0-17	0.5732	1.96	1	7
31	1	MED	Concussion Age >17 w cc	0.8143	2.48	1	8
32	1	MED	Concussion Age >17 w/o cc	0.6248	1.73	1	5
33	1	MED	Concussion Age 0-17	0.4138	1.27	1	3
34	1	MED	Other Disorders Of Nervous System w cc	1.3677	5.14	1	25
35	1	MED	Other Disorders Of Nervous System w/o cc	0.6525	2.81	1	10
36	2	SURG	Retinal Procedures	1.2018	1.77	1	13
37	2	SURG	Orbital Procedures	1.1668	3.12	1	11
38	2	SURG	Primary Iris Procedures	0.6185	1.67	1	5
39	2	SURG	Lens Procedures With Or Without Vitrectomy	0.9401	2.00	1	5

DRG Grouper 21.0 R2, effective for admissions on and after April 1, 2004.

List of Diagnosis Related Groups (DRGs), Relative Weight Factors, Arithmetic Length of Stays, and Length of Stay Outlier Cutoff Points used in the Prospective Payment System for the Michigan Medicaid Program.

DRG	MDC	Med/ Surg	DRG Description	Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
40	2	SURG	Extraocular Procedures Except Orbit Age >17	1.4233	3.89	1	14
41	2	SURG	Extraocular Procedures Except Orbit Age 0-17	2.3643	6.68	1	36
42	2	SURG	Intraocular Procedures Except Retina, Iris & Lens	1.2075	3.56	1	29
43	2	MED	Hyphema	0.4621	3.59	1	10
44	2	MED	Acute Major Eye Infections	0.5318	3.42	1	10
45	2	MED	Neurological Eye Disorders	0.7782	3.00	1	9
46	2	MED	Other Disorders Of The Eye Age >17 w cc	0.7643	3.56	1	10
47	2	MED	Other Disorders Of The Eye Age >17 w/o cc	0.5712	2.75	1	13
48	2	MED	Other Disorders Of The Eye Age 0-17	0.7599	3.58	1	17
49	3	SURG	Major Head & Neck Procedures	3.0032	3.11	1	16
50	3	SURG	Sialoadenectomy	0.8953	1.60	1	4
51	3	SURG	Salivary Gland Procedures Except Sialoadenectomy	1.2545	4.00	1	13
52	3	SURG	Cleft Lip & Palate Repair	0.7512	1.49	1	4
53	3	SURG	Sinus & Mastoid Procedures Age >17	1.4733	3.95	1	17
54	3	SURG	Sinus & Mastoid Procedures Age 0-17	1.3636	3.49	1	15
55	3	SURG	Miscellaneous Ear, Nose, Mouth & Throat Procedures	1.9605	5.09	1	27
56	3	SURG	Rhinoplasty	0.9904	2.17	1	9
57	3	SURG	T&A Proc, Except Tonsillectomy &/Or Adenoidectomy Only, Age >17	0.7872	3.10	1	13
58	3	SURG	T&A Proc, Except Tonsillectomy &/Or Adenoidectomy Only, Age 0-17	0.8762	2.90	1	9
59	3	SURG	Tonsillectomy &/Or Adenoidectomy Only, Age >17	0.9196	2.50	1	9
60	3	SURG	Tonsillectomy &/Or Adenoidectomy Only, Age 0-17	0.8220	2.50	1	11
61	3	SURG	Myringotomy w Tube Insertion Age >17	2.1087	5.43	1	11
62	3	SURG	Myringotomy w Tube Insertion Age 0-17	0.9419	2.71	1	14
63	3	SURG	Other Ear, Nose, Mouth & Throat O.R. Procedures	1.6265	3.18	1	12
64	3	MED	Ear, Nose, Mouth & Throat Malignancy	1.7883	7.38	1	22
65	3	MED	Dysequilibrium	0.6198	2.70	1	8
66	3	MED	Epistaxis	0.7063	2.93	1	9
67	3	MED	Epiglottitis	0.8748	3.00	1	8
68	3	MED	Otitis Media & Uri Age >17 w cc	0.6572	2.89	1	9
69	3	MED	Otitis Media & Uri Age >17 w/o cc	0.4550	2.28	1	6
70	3	MED	Otitis Media & Uri Age 0-17	0.4339	2.41	1	7
71	3	MED	Laryngotracheitis	0.3720	1.80	1	5
72	3	MED	Nasal Trauma & Deformity	0.7517	2.60	1	6
73	3	MED	Other Ear, Nose, Mouth & Throat Diagnoses Age >17	0.7579	3.34	1	11
74	3	MED	Other Ear, Nose, Mouth & Throat Diagnoses Age 0-17	0.7097	2.87	1	11
75	4	SURG	Major Chest Procedures	4.0386	11.64	1	43
76	4	SURG	Other Resp System O.R. Procedures w cc	3.7844	12.56	1	44

DRG Grouper 21.0 R2, effective for admissions on and after April 1, 2004.

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DRG	MDC	Med/ Surg	DRG Description	Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
77	4	SURG	Other Resp System O.R. Procedures w/o cc	1.2616	4.59	1	17
78	4	MED	Pulmonary Embolism	1.5425	6.46	1	16
79	4	MED	Respiratory Infections & Inflammations Age >17 w cc	2.1388	8.97	2	28
80	4	MED	Respiratory Infections & Inflammations Age >17 w/o cc	1.2278	5.93	1	23
81	4	MED	Respiratory Infections & Inflammations Age 0-17	1.6943	7.20	1	21
82	4	MED	Respiratory Neoplasms	1.8985	7.50	1	26
83	4	MED	Major Chest Trauma w cc	0.9827	3.35	1	9
84	4	MED	Major Chest Trauma w/o cc	0.5449	3.00	1	7
85	4	MED	Pleural Effusion w cc	1.4391	5.78	1	18
86	4	MED	Pleural Effusion w/o cc	0.6394	2.89	1	7
87	4	MED	Pulmonary Edema & Respiratory Failure	2.3585	7.19	1	32
88	4	MED	Chronic Obstructive Pulmonary Disease	1.0625	4.48	1	12
89	4	MED	Simple Pneumonia & Pleurisy Age >17 w cc	1.2232	5.25	1	15
90	4	MED	Simple Pneumonia & Pleurisy Age >17 w/o cc	0.7472	3.48	1	9
91	4	MED	Simple Pneumonia & Pleurisy Age 0-17	0.6279	3.11	1	9
92	4	MED	Interstitial Lung Disease w cc	1.6993	7.33	1	38
93	4	MED	Interstitial Lung Disease w/o cc	0.9159	4.33	1	16
94	4	MED	Pneumothorax w cc	1.2120	5.33	1	20
95	4	MED	Pneumothorax w/o cc	0.6534	3.46	1	9
96	4	MED	Bronchitis & Asthma Age >17 w cc	0.8466	3.71	1	11
97	4	MED	Bronchitis & Asthma Age >17 w/o cc	0.5941	2.71	1	7
98	4	MED	Bronchitis & Asthma Age 0-17	0.5198	2.60	1	7
99	4	MED	Respiratory Signs & Symptoms w cc	0.8426	3.11	1	11
100	4	MED	Respiratory Signs & Symptoms w/o cc	0.5005	2.12	1	6
101	4	MED	Other Respiratory System Diagnoses w cc	0.9691	3.66	1	13
102	4	MED	Other Respiratory System Diagnoses w/o cc	0.5370	2.14	1	7
103	PRE	SURG	Heart Transplant	***Paid Percentage of Charge***			
104	5	SURG	Cardiac Valve & Oth Major Cardiothoracic Proc w Card Cath	9.4908	18.50	1	50
105	5	SURG	Cardiac Valve & Oth Major Cardiothoracic Proc w/o Card Cath	6.3833	10.96	3	42
106	5	SURG	Coronary Bypass w Ptca	7.1670	11.73	1	35
107	5	SURG	Coronary Bypass w Cardiac Cath	5.8389	10.73	4	29
108	5	SURG	Other Cardiothoracic Procedures	5.5318	9.94	1	40
109	5	SURG	Coronary Bypass w/o Ptca Or Cardiac Cath	3.9537	7.16	3	21
110	5	SURG	Major Cardiovascular Procedures w cc	5.2728	10.80	1	42
111	5	SURG	Major Cardiovascular Procedures w/o cc	2.4897	4.56	1	12
112	5	SURG	No Longer Valid				
113	5	SURG	Amputation For Circ System Disorders Except Upper Limb & Toe	4.4204	16.59	3	47
114	5	SURG	Upper Limb & Toe Amputation For Circ System Disorders	2.4172	9.96	1	34
115	5	SURG	Prm Card Pacem Impl w Ami/Hr/Shock Or Aicd	4.7810	8.55	1	30

DRG Grouper 21.0 R2, effective for admissions on and after April 1, 2004.

List of Diagnosis Related Groups (DRGs), Relative Weight Factors, Arithmetic Length of Stays, and Length of Stay Outlier Cutoff Points used in the Prospective Payment System for the Michigan Medicaid Program.

DRG	MDC	Med/ Surg	DRG Description	Relative Weight	Average LOS	Low Day Threshold	High Day Threshold
			Lead Or Gnrtr				
116	5	SURG	Other Permanent Cardiac Pacemaker Implant	3.1637	4.94	1	18
117	5	SURG	Cardiac Pacemaker Revision Except Device Replacement	1.8957	5.35	1	37
118	5	SURG	Cardiac Pacemaker Device Replacement	2.2531	4.46	1	22
119	5	SURG	Vein Ligation & Stripping	1.0323	5.17	1	15
120	5	SURG	Other Circulatory System O.R. Procedures	3.1368	10.38	1	37
121	5	MED	Circulatory Disorders w Ami & Major Comp, Discharged Alive	2.5012	6.18	1	20
122	5	MED	Circulatory Disorders w Ami w/o Major Comp, Discharged Alive	1.5645	3.48	1	9
123	5	MED	Circulatory Disorders w Ami, Expired	2.1430	4.08	1	20
124	5	MED	Circulatory Disorders Except Ami, w Card Cath & Complex Diag	1.7674	4.69	1	15
125	5	MED	Circulatory Disorders Except Ami, w Card Cath w/o Complex Diag	1.2483	2.85	1	9
126	5	MED	Acute & Subacute Endocarditis	4.0058	16.08	1	47
127	5	MED	Heart Failure & Shock	1.2325	4.86	1	15
128	5	MED	Deep Vein Thrombophlebitis	0.9688	5.28	1	11
129	5	MED	Cardiac Arrest, Unexplained	1.2880	2.13	1	12
130	5	MED	Peripheral Vascular Disorders w cc	1.2565	6.35	1	20
131	5	MED	Peripheral Vascular Disorders w/o cc	0.8254	4.84	1	10
132	5	MED	Atherosclerosis w cc	0.8423	2.72	1	8
133	5	MED	Atherosclerosis w/o cc	0.7911	2.30	1	7
134	5	MED	Hypertension	0.7945	3.18	1	10
135	5	MED	Cardiac Congenital & Valvular Disorders Age >17 w cc	1.4084	4.69	1	27
136	5	MED	Cardiac Congenital & Valvular Disorders Age >17 w/o cc	0.6157	2.40	1	7
137	5	MED	Cardiac Congenital & Valvular Disorders Age 0-17	1.7581	5.31	1	33
138	5	MED	Cardiac Arrhythmia & Conduction Disorders w cc	1.0567	3.70	1	12
139	5	MED	Cardiac Arrhythmia & Conduction Disorders w/o cc	0.6174	2.13	1	7
140	5	MED	Angina Pectoris	0.7732	2.37	1	6
141	5	MED	Syncope & Collapse w cc	0.8213	3.23	1	10
142	5	MED	Syncope & Collapse w/o cc	0.6353	2.29	1	6
143	5	MED	Chest Pain	0.6659	2.04	1	6
144	5	MED	Other Circulatory System Diagnoses w cc	1.6823	6.61	1	25
145	5	MED	Other Circulatory System Diagnoses w/o cc	0.8681	3.13	1	10
146	6	SURG	Rectal Resection w cc	3.0127	10.54	4	42
147	6	SURG	Rectal Resection w/o cc	2.2545	7.00	1	17
148	6	SURG	Major Small & Large Bowel Procedures w cc	4.2668	13.67	3	44
149	6	SURG	Major Small & Large Bowel Procedures w/o cc	1.8772	6.73	2	16
150	6	SURG	Peritoneal Adhesiolysis w cc	2.9953	10.97	2	40
151	6	SURG	Peritoneal Adhesiolysis w/o cc	1.4694	4.96	1	14